TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WILLIAM URSPRUNG, DC

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-17-0855-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DR REFERRED TESTING NO PAYMENT RECEIVED."

Amount Sought: $805.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the requestor was not an authorized provider. The claimant has treated with Dr. Concepcion Martinez and Dr. Francisco Garcia, M.D. The requesting provider was not a referral from the treating doctor, but from a non-treating orthopedic (Dr. Kugler). "

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount Sought	Amount Due
May 23, 2016	Functional Capacity Evaluation (FCE) CPT Code 97750-FC (16 units)	$805.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement for the service in dispute.
3. 28 Texas Administrative Code §127.10 sets out the procedures for designated doctors.
4. Texas Insurance Code §1305.003 sets limitations on applicability of Texas Insurance Code Chapter 1305.
5. Texas Labor Code §408.0041 grants the Division of Workers' Compensation the authority to order designated doctor examinations.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Services not provided by Designated provider.

- 36-Services not provided or authorized by designated (network/primary care) providers.

Issues

1. Does the network complaint process apply?
2. Does the submitted documentation support the disputed FCE was performed at request of Designated Doctor? Is reimbursement due for the FCE in dispute?

Findings

1. The respondent denied reimbursement for the disputed FCE rendered on May 23, 2016 based upon "36-Services not provided or authorized by designated (network/primary care) providers." The respondent stated that "the requestor was not an authorized provider. The claimant has treated with Dr. Concepcion Martinez and Dr. Francisco Garcia, M.D. The requesting provider was not a referral from the treating doctor, but from a non-treating orthopedic (Dr. Kugler). "

   The requestor contends that reimbursement is due because "The provider IS NOT required to be in the insurance carrier's network for Designated Doctor referred testing."

   The requestor contends that the referral for the FCE in this dispute was made by a designated doctor. Such referrals are authorized under the Texas Labor Code and division rules. Texas Insurance Code Chapter 1305 contains a provision which limits applicability of certain 1305 Network requirements when they adversely affect powers granted to the division under the Labor Code.

   Texas Insurance Code §1305.003 titled LIMITATIONS ON APPLICABILITY states that:

   (a) This chapter [TIC 1305] does not affect the authority of the division of workers' compensation of the department to exercise the powers granted to the division under Title 5, Labor Code, that do not conflict with this chapter [TIC 1305].

   Texas Labor Code §408.0041 grants the division the exclusive authority to order a designated doctor to examine any injured employee and resolve questions or disputes over the injured employee's medical condition. 28 Texas Administrative Code §127.10 in turn authorizes designated doctors to make referrals when necessary to resolve the question(s) the designated doctor was ordered to address.

   If the FCE was performed as a result of a designated doctor referral, the appropriate remedy for review is the division's medical fee dispute resolution process.

2. The requestor asserts that reimbursement is due because the disputed FCE was performed at the request of the Designated Doctor, Carlos Kugler, MD. A review of the submitted documentation finds no documentation to support the Division scheduled a Designated Doctor examination with Dr. Kugler. That Dr. Kugler performed a Designated Doctor examination, and that he referred claimant to requestor for the FCE as part of the examination. Therefore, the Division finds that the requestor has not supported position that the disputed FCE was performed as part of a Designated Doctor evaluation. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/22/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.